

# A Homeless Shelter Medical Clinic Organized and Staffed by Family Practice Residents

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A medical clinic was organized in a homeless shelter to help address the health care needs of the homeless population in a small California city. A second-year family practice resident, together with two community nurses and a local family practitioner, organized and staffed the clinic. After the first winter of operation, family practice residents on their own initiative took over the management of the clinic. The clinic serves the needs of the clients in the homeless shelter, provides family practice residents an opportunity to work independently of the residency program, and offers a sought-after experience in caring for the underserved.

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**H**omelessness in America is, unfortunately, a growing problem. Recent estimates of the homeless population range from 350,000 to 600,000, with families identified as the fastest growing homeless group (*CQ Researcher*, August 7, 1992, p 675).<sup>1,2</sup> Although many communities have developed emergency shelters to provide temporary housing, many of the people using these shelters are in poor health or at the very least lack ongoing health care and frequently use emergency departments as their only contact with the health care community. The Stewart B. McKinney Homeless Assistance Act of 1987, which mandated funds to provide primary care to homeless persons, represents an attempt to meet the challenge of providing health care to this population on a national level. In many communities, however, volunteer efforts were undertaken to meet the medical needs of the homeless.<sup>3</sup>

## Medical Problems of Homeless Persons

Although homeless people suffer all the illnesses of domiciled persons, they are also at much higher risk for many medical problems. Some of these problems stem from self-selected behaviors, including tobacco and illegal drug use. Current or past drug abuse was reported by 85% of the men and 67% of the women in one homeless shelter.<sup>4</sup> In Atlanta, Georgia, the average age of death for homeless persons was 46 years, with nearly half of the deaths attributed to acute or chronic effects of alcohol abuse.<sup>5</sup> Homeless persons also appear to suffer from chronic illnesses at a much higher rate than the general public, with 40% to 75% of homeless reporting chronic health problems.<sup>6,7</sup> In larger cities, the spread of tuberculosis among homeless persons has become almost epi-

demic. This problem is compounded by the close living quarters in many of the shelters and the difficulty in ensuring that infected persons comply with their therapy.<sup>8,9</sup> Another epidemic that affects homeless persons more frequently than the domiciled is that of accidents and violence. In one study, 40% of homeless persons reported suffering an accident in the previous two months, and in a study from Georgia, 42% of deaths in homeless persons were due to accidents or violence.<sup>5,6</sup>

Families and children appear to suffer inordinately in the homeless environment. A study of homeless families revealed that the overwhelming proportion of them are headed by a single unemployed woman with minimal support, many with compounding mental health and substance abuse problems.<sup>10</sup> Children in the homeless environment have chronic illness at twice the rate of the general population, trail in immunizations, and are developmentally delayed at an alarming rate.<sup>10-12</sup> The greatest threat to the well-being of homeless children and adolescents may be psychosocial development. Homeless adolescents are often fleeing a hostile home environment, one in which they may have suffered abuse and neglect.<sup>13</sup> Numerous studies have shown that homeless children have a higher frequency of behavior problems (particularly antisocial behavior) than domiciled children and report a much higher incidence of depressive symptoms and ideation.<sup>13-15</sup>

## Redding, California, Demographics

Redding is a city of about 66,000 at the northern end of the Sacramento Valley of California. It developed as, and still is, a major rest stop for travelers heading up and down the valley. In 1989 the unemployment rate averaged approximately 9.2%, and about 9,000 families or persons were receiving government assistance.<sup>16</sup>

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## Redding Armory Homeless Shelter and Medical Clinic

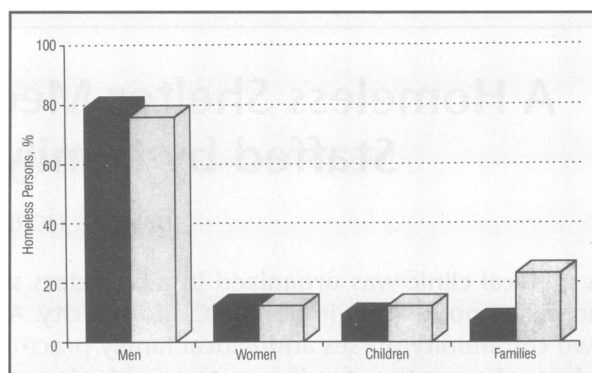
To assist homeless persons in the city of Redding, the Salvation Army and People of Progress joined forces in 1988 to set up a shelter to operate during the winter months. Impromptu health care stations were set up on a sporadic basis in the latter part of the first season. In the fall of 1989, a second-year family practice resident collaborated with the nurses and physician who had previously provided services to the shelter. To provide some continuity of care, they arranged to operate a clinic on a weekly basis.

For the first year of operation, the clinic was staffed by one resident and one practicing family physician, two nurses, and, when possible, a social worker and a mental health worker. On-site medications were kept to a minimum, with the intent to refer most ongoing health problems to appropriate resources. Experience from the previous year had indicated that most of the homeless clients were eligible for one of three health systems that served the indigent population: Shasta County Clinic, Department of Veterans Affairs, or Indian Health Services. These services were substantially underused, however, with most homeless persons visiting emergency departments as their only contact with health care providers. Backup radiology and laboratory evaluations were done, free of charge, by the resident's hospital, with professional fees waived by the respective departments. A prescription charge account was set up at a local pharmacy through funds donated by the Redding Rotary Club.

The dual goals of the clinic organizers were to provide health care services to persons who had inadequate primary care and to familiarize family practice residents with the health care problems of homeless persons. One of the major impediments to recruiting physicians to work in indigent and homeless care settings is overcoming physician biases and fears.<sup>3</sup> By providing residents a positive experience in a homeless shelter, the organizers believed that these biases and fears could be alleviated.

## Methods

Client use and demographic data for the shelter were recorded and compiled by shelter staff personnel from



**Figure 1.**—The graph shows a breakdown of the homeless shelter (■) (n = 663) and medical clinic (□) (n = 183) clients by families, men, women, and children.

the Salvation Army. Clinic use was recorded by volunteer medical records personnel. Brief medical records were kept on all clients seen in the clinic, with the recording of name, complaint, diagnosis, treatment, and referral, if indicated. Family status was recorded on all patients. Data were entered in a computer database for sorting and analysis.

## Outcome

During the 1989-1990 winter season (December through March), the shelter was open for 113 nights and lodged 663 persons; there was an average of 63 clients per night, for a total of 7,098 lodgings provided. The shelter demographics were similar to those of other shelters, with men (especially veterans) overrepresented (Table 1).<sup>17,18</sup> Use of the clinic was proportionally higher for children and families, however, than it was for single men (Figure 1).

During this period, the clinic saw 278 clients and dispensed 205 medications (to 160 clients). Upper respiratory tract infection, skin problems, and pharyngitis accounted for almost a third of the visits. Hypertension and chronic obstructive pulmonary disease (COPD) accounted for another 10% of visits (Figure 2). Of 186 referrals made, only 1 was to an emergency department. The rest of the referrals were to either the Medi-Cal office (California's Medicare), Indian Health Services, or Veterans Affairs clinics.

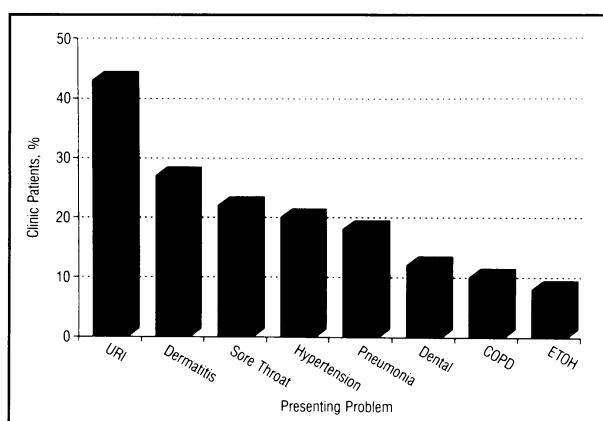
## Discussion

### Medical Issues

The homeless persons served by this clinic appeared to be in better health than those in studies done in major cities.<sup>2,4,19</sup> The clients did, however, have a notably high rate of chronic disease, such as COPD and hypertension, that frequently was untreated. One of the primary goals of this clinic was to assist the clients of the shelter in taking care of their health needs by referring them to the appropriate medical resource. The success in meeting this goal is reflected by the high referral rate to the coun-

**TABLE 1.**—Demographics of Homeless Shelter (n = 663) and Medical Clinic (n = 183) Clients

Demographics	Homeless Shelter, No. (%)	Medical Clinic, No. (%)
White.....	609 (92)	150 (87)
Hispanic.....	20 (3)	20 (5)
Black.....	14 (2)	4 (2)
Native American.....	19 (3)	9 (5)
Asian.....	1 (0.2)	0 (0)
Veteran.....	177 (27)	40 (23)
County resident.....	229 (35)	69 (40)
Nonresident.....	434 (65)	114 (60)



**Figure 2.**—The graph shows the presenting problems of patients seen at the medical clinic (n = 183). COPD = chronic obstructive pulmonary disease, ETOH = ethyl alcohol [alcohol-related disorders], URI = upper respiratory [tract] infection

ty's indigent clinics, with only one referral to an emergency department.

Although official data are unavailable, conversations with physicians and directors of the two emergency departments in Redding suggest that there has been a decreased use of the emergency departments by homeless persons since the clinic started operation.

### *Educational Issues*

Studies on the integration of a homeless shelter experience into family practice residencies have reported increased awareness of the problems facing homeless persons and increased comfort in dealing with this population.<sup>20-22</sup> In one study it was found that as little as half a day of working in a homeless shelter substantially improved the residents' understanding of the causes and implications of homelessness.<sup>22</sup> In 1990, a pilot education and research elective was developed for residents and students working in a homeless shelter.<sup>23</sup> Consistent with the Redding experience, it was reported that residents rated the elective positively and that requests for the elective quickly outpaced availability.

Whereas the clinic experience has been well received by the family practice residents, it has not been without difficulties. Many shelter patients have complex medical histories that initially seemed overwhelming to some of the residents. Although most of the residents welcomed the opportunity to work independently from the residency program, this, too, was intimidating to a few of them. There were also difficulties in the care of some of the patients, especially with compliance. We were able to improve compliance as we became more familiar with some of the difficulties facing homeless persons—lack of money and transportation, unstructured lifestyle, poor social support.

In 1995 the clinic continued to operate in a similar manner, with the second- and third-year residents volunteering to staff it on a rotating basis. In staffing the clinic, the residents do not gain any credit toward their res-

idency requirements. Responsibility for organizing staffing and supplies for the clinic has also been taken over by one of the residents each year. In the years since the clinic has become a "resident project," nearly every resident who has graduated from the family practice program has worked at least one shift in the clinic. In fact, residents have found it difficult to get scheduled as the "Shelter Doc" unless they volunteer early. They say that they value the unique experience of working with a difficult group of patients with complex psychosocial issues in the clients' own, rather than the physician's, environment.

The residency administration decided to continue supporting the shelter clinic without formally incorporating it into the residency program. This policy has allowed the residency to include coverage of the shelter clinic in its malpractice insurance, while maintaining the clinic's truly volunteer nature. It has been continued as a "residents' project" rather than a "residency project." By adopting it as their own project, the residents have personally invested in the shelter clinic. This probably would not have occurred if it had become a required element of the residents' training. The project has also provided some of the residents the experience of being personally in charge of the organization and daily management of a fairly complex clinic. Most important, however, this policy has encouraged the residents not only to gain a valuable learning experience, but also to attain a sense of fulfillment that comes from performing charitable work with clients who clearly need their services. The residents look forward to working in the clinic, even though they get no time off from their already busy schedules and gain no official recognition for their time and effort at the clinic. Studies suggest that exposing students, and residents, to underserved populations such as the homeless increases their awareness of professional values such as altruism and equality.<sup>24</sup> This experience may help encourage the physicians who graduate from the program to continue to seek the joys that come from helping people who need it, without regard to compensation.

### **Acknowledgment**

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\* \* \*

## The #1 Cause of Death

They are telling doctors how to ask  
The right questions; to get to the truth  
Beneath the clenched jaws, silence and bruises.  
But what is the proper remedy?

Here, take two aspirins, and hide;  
Take your children now to the shelter  
Don't wait for more proof.  
You will never be secure,  
It will not go away;  
He will kill you if you take it long enough.  
You are the real Cinderella  
The glass slipper fits;

Except there is something wrong with the prince—  
Inside his mind the violence builds to explosions  
Like atomic bombs in your life—  
Your livingroom and your kitchen  
Are full of land mines;  
You are in a war zone  
Weaponless and weeping  
Oh, for the love of God and your children, Leave!  
I write this as an Rx,  
as your physician I order you—  
As a mother I beg you,  
Do not stop to feel defeated, just move,  
Keep your feet on the path to the shelter,  
Later, later, you can grieve.

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